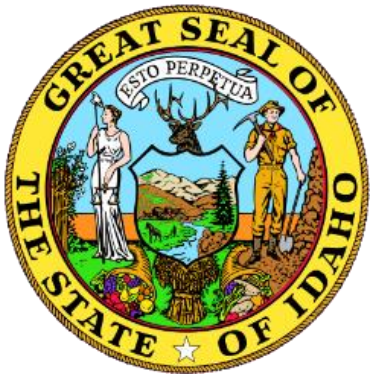
IDAHO MEDICAID MANAGED CARE QUALITY STRATEGY: MEDICARE MEDICAID COORDINATED PLAN



Idaho Department of Health and Welfare, Division of Medicaid

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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Section I: Introduction

Managed Care Overview, Goals and Objectives

History of Medicaid Managed Care in Idaho

The Idaho Department of Health and Welfare (IDHW) began to explore Medicaid managed care with the implementation of the Idaho Medicare Medicaid Coordinated Plan (MMCP) in 2006. The MMCP, under a Prepaid Ambulatory Health Plan agreement, coordinated Medicare Parts A and B benefits with certain outpatient Medicaid services for individuals dually eligible for Medicare and Medicaid. However, under this plan, a number of Medicaid benefits remained carved out and continued to be administered by the Division of Medicaid via a fee-for-service model, including inpatient services and Medicaid long-term services and supports (LTSS). The MMCP was a first step in integrating Medicare and Medicaid benefits for Idaho dual eligibles, even though these payer systems were not originally designed to work in tandem.

Since the launch of the MMCP in 2006, IDHW has engaged in other Medicaid managed care initiatives to better serve the population in Idaho in a cost-effective manner. The Patient Centered Medical Home (PCMH) model, which expanded February 2016, includes a tiered incentive structure for primary care providers to improve patient care and better coordinate services.

Idaho Medicaid also offers dental benefits and behavioral health benefits in managed care models under Prepaid Ambulatory Health Plans; the Idaho Smiles program and the Idaho Behavioral Health Plan both serve individuals with special health care needs that qualify for Enhanced Medicaid State Plan services.

MMCP Expansion

As a result of the passage of House Bill 260 in 2011, the Idaho Legislature directed Idaho Medicaid to develop a managed care program for the high-cost dual eligible population that would result in an accountable care system and improved health outcomes. Shortly thereafter, Idaho Medicaid began working with stakeholder groups to develop a comprehensive expansion to the existing MMCP that would better integrate Medicare and Medicaid benefits for Idaho's dual eligibles and introduce a new care management component. The Medicare and Medicaid systems were not initially designed to operate in an integrated fashion, oftentimes resulting in fragmented care, poor outcomes, and higher costs for the dual eligible population. The goal of the expanded MMCP is to increase access to comprehensive care within a care management model and improve health outcomes for participants whose benefits historically have not been well coordinated.

The Scope of Work (SOW) for the expanded MMCP was executed May 2014 and approved by the Centers for Medicare and Medicaid Services (CMS) in June 2014. The program launched in July 2014. The expanded MMCP, under a Managed Care Organization (MCO) contract, is a voluntary opt-in Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) available to individuals over age 21 that are eligible for Medicare Parts A and B and Medicaid. This plan is not available to those with Medicare as a result of having End-Stage Renal Disease or those with limited Medicaid benefits. IDHW looks forward to

analyzing MMCP encounter data once it becomes available to determine if the MMCP results in cost savings and improved coordination of care for those duals that opt into the program.

Idaho Medicaid's Quality Management Structure

The Bureau of Long Term Care (BLTC) is responsible for direct oversight of the MMCP. QA staff within the Bureau operate under the supervision of the Quality Program Manager and are responsible for quality oversight of Idaho's Aged and Disabled 1915(c) waiver and State Plan Personal Care Services. Bureau Nurse Managers and Program Managers conduct internal file audits, while QA staff complete provider training and reviews and document and investigate Complaints and Critical Incidents relating to services under the purview of BLTC. A Contract Monitor within the BLTC maintains oversight of the MMCP quality assurance activities and reporting. Where there is overlap between MMCP activities and BLTC activities, such as the assessment for and delivery of long-term services and supports under Idaho's Aged and Disabled waiver, the Contract Monitor facilitates oversight activities.

At the Division level, the Central Office Management Team (COMT) maintains global oversight of all Medicaid activities, including quality assurance activities. COMT consists of the Bureau Chiefs in addition to the Administrator and Deputy Administrators of the Division of Medicaid.

The Medical Care Advisory Committee (MCAC) advises Idaho Medicaid in the development and refining of the overall Medicaid program by providing a sounding board and, as an advisory group, gives Idaho Medicaid feedback on current and evolving issues in Medicaid. Advocates, service providers, and public agencies strive to work together and share their experience and knowledge to maximize the care available to Idaho Medicaid participants. Membership is comprised of Medicaid participants and/or family/personal representatives, consumer groups on behalf of Medicaid participants and members of the general public who are concerned about health service delivery to the Medicaid population; healthcare professionals who serve the Medicaid population, and other individuals with relevant Medicaid knowledge and background in healthcare such as, but not limited to acute care, behavioral health, long term care, home care, Medicaid law and policy, healthcare financing, quality assurance, patient rights, health planning, and pharmacy care.

The Personal Assistance Oversight Committee (PAOC), a subcommittee of the MCAC, monitors and recommends changes to the Medicaid waiver and personal assistance programs. Such recommendations are submitted to the MCAC. The PAOC consists of providers of personal assistance services and participants of such services, advocacy organizations representing such participants, and other interested parties.

Development & Review of Quality Strategy (§438.202(b))

IDHW developed the quality strategy following the development and launch of the expanded MMCP. Stakeholders will be advised of the availability of the draft Quality Strategy during the regular MMCP stakeholder webinar open to participants, providers, advocates, and other interested parties; stakeholders will also be notified at the Medical Care Advisory Committee, Personal Assistance Oversight Committee, and Tribal quarterly meetings. Once ready in draft form, the Quality Strategy will be posted for public feedback on the IDHW website dedicated to the MMCP. Stakeholders will be

notified of the comment period via the same communication channels mentioned above and during the next semi-annual statewide dual eligible outreach forums in the spring of 2016.

The effectiveness of the Quality Strategy will be assessed annually and updated at that time if needed to reflect the current landscape of Idaho's Medicaid managed care programs. It will be updated more frequently should there be a significant change, which includes any expansion of the managed care model to other populations or programs or any amendments to the MMCP SOW that result in a significant shift or expansion of the quality measurement protocols.

Section II: Assessment

Quality and Appropriateness of Care (§438.204(b)(1))

IDHW assesses the quality and appropriateness of care and services furnished to enrollees in the MMCP by means of a robust constellation of contract monitoring and quality assurance activities. The Health Plan submits monthly, quarterly, and annual reports according to report specifications that are outlined in the SOW which address a variety of metrics. These reports include a grievance and appeals report, a complaint and critical incident tracking and resolution report, a denial of services report, a care coordination report, and a high-cost claimants report, among others. The Contract Monitor may request ad hoc reports and additional data if potential concerns regarding quality and appropriateness of care are identified. Complaints about quality or appropriateness of care and services furnished by the MMCP that are received by the Division of Medicaid are tracked internally and investigated by the Contract Monitor. In addition, the Contract Monitor conducts quarterly on-site visits with the Health Plan, during which random sample file audits are completed. IDHW requests a corrective action plan when significant isolated or systemic quality and appropriateness of care issues are identified and validated.

Special health care needs are defined as any physical, developmental, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, health care intervention, and/or use of specialized services or programs beyond those typically required by the general population. The MMCP serves only dually eligible Medicaid and Medicare beneficiaries; accordingly, the entire plan population consists of individuals who are elderly, disabled, or both. All enrollees fall into a continuum of special health care needs. Enrollee-specific needs are identified during the comprehensive health risk assessment which is completed within ninety (90) days of enrollment in the plan; enrollees are subsequently assigned a risk tier that dictates the minimum required frequency of contact with those persons in addition to the intensity of care management activities warranted by the individual's needs. This risk stratification is supplied to the IDHW on a monthly basis in a care coordination report. The IDHW Contract Monitor uses this report to cross-reference other data sources and identify any deficiencies in the Health Plan's performance with respect to serving customers across the entire spectrum of risk levels.

Race, Ethnicity, and Language Data (§438.204(b)(2))

Enrollee race, ethnicity, and primary language data is collected at the time of initial application and verified at ongoing annual reevaluation for Medicaid financial eligibility via the IDHW Division of Self

Reliance. This data is entered into the Idaho Benefit Eligibility System (IBES) which is subsequently loaded into the MMIS during a nightly data transfer. This data is supplied to the Health Plan via a secured automated file transfer system upon enrollment into the plan. In addition, the Health Plan confirms this data during the comprehensive health risk assessment process and accommodations are made as needed and as required by the SOW.

National Performance Measures (§438.204(c))

CMS has not identified any required national performance measures for Medicaid MCOs at this time. The IDHW is not currently collecting CMS or national core performance measures for the MMCP population. The Health Plan administering the MMCP at the time of writing, Blue Cross of Idaho Care Plus, Inc., is subject to Chapter Five – Quality Improvement Program of the Medicare Managed Care Manual. This includes a Chronic Care Improvement Program, a Quality Improvement Project, HEDIS Reporting, and CAHPS requirements. MMCP enrollees are included in the overall population served by the Health Plan when collecting these data elements.

Monitoring and Compliance (§438.204(b)(3))

The Health Plan administering the MMCP must comply with the Idaho Medicaid Provider Agreement terms in addition to the SOW Special Terms and Conditions that are specific to the administration of the MMCP. The IDHW has specified within the SOW an array of performance thresholds, monitoring activities, and reporting requirements to ensure the Health Plan meets expectations as outlined in the agreement and the federal requirements for quality assessment and performance improvement described in 42 CFR 438 Subpart D. Reports required of the Health Plan include:

- *Provider Network Reports*
    - *Provider Enrollment File* (due annually). This report includes a list of current Medicaid-only service providers and their provider type/specialty.
    - *Geographical Access Report* (due annually). This report includes the number of network providers by type and specialty in each county. In addition, the report must indicate the percentage of Enrollees who have a PCP and behavioral health provider within thirty (30) miles of their residence for Ada, Canyon, Twin Falls, Nez Perce, Kootenai, Bannock, and Bonneville counties; and forty-five (45) miles of their residence for all other counties in Idaho.
    - *Timeliness of Service Report* (due annually). This report includes the Health Plan's survey of its network providers, including the percentage of providers who have met the acceptable timeframe requirements identified in the Service Delivery Standards section of the SOW, any justification for providers that did not meet the access standard requirements, and any identified trends in providers that did not meet the standards.
    - *Assessment and Care Coordination Report* (due monthly). This report includes the number and percent of Enrollees with initial comprehensive health risk assessments completed within thirty (30), sixty (60), and ninety (90) calendar days of initial enrollment, including the name and credentials of the staff person completing the assessment and the total number of Enrollees assigned to each Care Coordinator.

- *Provider Payment Reports*
    - *Enrollment/Capitation Payment Reconciliation Report* (due monthly). This report identifies any Enrollees for whom a capitation payment has not been made or if an incorrect payment has been made.
    - *Provider Payment Report* (due quarterly). This report identifies (1) The percent of electronic clean claims paid within thirty (30) calendar days of receipt of the claim; (2) percent of electronic clean claims denied within thirty (30) calendar days of receipt of the claim; (3) percent of all electronic clean claims paid within ninety (90) calendar days of receipt of the claim; (4) percent of all electronic clean claims denied within ninety (90) calendar days of receipt of the claim; (5) percent of paper clean claims paid within forty five (45) calendar days of receipt of the claim; (6) percent of paper clean claims denied within forty-five (45) calendar days of receipt of the claim; (7) percent of all paper clean claims paid within ninety (90) calendar days; (8) percent of all paper clean claims denied within ninety (90) calendar days.
- *Utilization Management Reports*
    - *High-Cost Claimants Report* (due quarterly). This report details Enrollees who incurred non-nursing facility claims in excess of twenty-five thousand dollars ($25,000). The report includes each Enrollee's age, sex, primary diagnosis, and amount paid by claim type for each identified Enrollee. The name and other identifying information about the Enrollee shall be blinded to maintain confidentiality. The report shall also detail all efforts made to ensure the Enrollee's services are coordinated, communicated to the interdisciplinary care team, addressed in the Individualized Care Plan, and that the Enrollee is aware of and is participating in the appropriate disease management or case management services.
    - *Aged and Disabled Waiver Utilization Report* (due monthly). This report includes a summary overview that details the number of Aged and Disabled Waiver Enrollees and Personal Care Services Enrollees, including the Enrollee's name, assigned identifiers, and secondary rate code when applicable. The report shall also include detailed Enrollee data for individuals who have not received service within the last thirty (30) calendar days, including service group, date of last long-term care service, length of time without long-term care services, and the reason why the Enrollee has not received services. Idaho Home Choice Money Follows the Person (IHCMFP) participants who are Enrollees will be identified separately for each data element.
    - *Emergency Department Threshold Report* (due semiannually). This report identifies the number of Emergency Department visits by Enrollee by calendar month. The report also includes Enrollees with utilization exceeding ten (10) or more visits in a six (6) month period, in addition to the likely cause of the high utilization, the plan for those Enrollees to assist with reducing inappropriate utilization, and those Enrollees who were contacted by the Care Coordinator or PCP for the purposes of providing education on appropriate ED utilization.
    - *Drug Utilization Report for Rebates* (due monthly). This report includes drug utilization data for all non-Part B and non-Part D drugs provided to Enrollees and includes

information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed, including those drugs administered by physicians in their offices.
    - *Provider Satisfaction with Utilization Management* (due annually). This report includes the results of a survey of Provider/office staff satisfaction with utilization management processes, a summary of areas identified for improvement, and the Health Plan's responses to areas identified for improvement.
- *Quality Management/Quality Improvement Reports*
    - *Aged and Disabled Waiver Consumer Direction of HCBS Report* (due quarterly). This report includes data pertaining to Aged and Disabled Waiver Enrollees who are enrolled in or referred for participation in self-direction of Home and Community Based Services (HCBS). Specific data elements are detailed in the SOW.
    - *Idaho Home Choice Money Follows the Person (IHCMFP) Participants Report* (due quarterly). This report includes data pertaining to Enrollees who are IHCMFP participants, including information on Enrollees who are in the process of transitioning into the community, such as claims details, living arrangement, services utilized, readmissions, etc. Specific data elements are detailed in the SOW.
- *Customer Service/Provider Service Reports*
    - *Call Center/Help Desk Report* (due quarterly). This report includes data regarding the number of calls received each month during the quarter, the types of calls received, and the timeframes for calls.
    - *Nurse Advice Line* (due annually). This report details the number of calls received and call data regarding timelines, the types of calls received, and the dispositions of calls received.
    - *Critical Incident Resolution Report* (due quarterly). This report includes data regarding critical incidents received during the quarter, including assigned priority levels, Enrollee information, and response timeframes and details.
    - *Grievances, Appeals, and Complaints Report* (due monthly). This report includes data elements for all grievances, appeals, and complaints received by the Health Plan.
- *Fraud and Abuse Report – Involuntary Terminations and Fraud Activities Report* (due Quarterly). This report identifies any Health Plan Providers that are investigated or terminated for fraud or abuse, in addition to transition plans for Enrollees utilizing terminated providers.
- *Financial Management Reports.*
    - *Recovery and Cost Avoidance Report* (due quarterly). This report includes recoveries from third party resources as well as funds for which the Health Plan does not pay a claim due to third-party liability coverage.
    - *Other Insurance Report* (due quarterly). This report includes information regarding any Enrollees with other insurance, including long-term care insurance.
    - *Medical Loss Ratio Report.* (due monthly) This report includes all medical expenses and completed supporting claims lag tables.
- *Claims Management Reports.*

    - *Claims Payment Accuracy Report* (due monthly). This report includes the results of the internal audit of a random sample of all paid claims for Medicaid services, indicating the number and percent of claims that are paid accurately.
    - *Claims Activity Report* (due monthly). This report includes the number of claims for Medicaid services received by the Health Plan, the number of claims denied, the number of claims paid, number of adjustments, and total dollar value of claims billed.
- *Information Systems Reports.*
    - *Systems Problem Report* (due within five (5) business days of the occurrence of a problem with system availability). This report details any issues with system availability and includes a plan that describes how the Health Plan will prevent the problem from recurring.
    - *Systems Availability and Performance Report* (due monthly). This report includes information on the availability and unavailability of major systems, including scheduled maintenance.
    - *Reporting on Controls at a Service Organization* (due annually). This report is a copy of an SSAE, SOC 1, Type II audit of the Health Plan performed annually.
    - *Contingency and Continuity Testing Report* (due annually). This report details the annual exercises conducted by the Health Plan to test current versions of information system contingency and continuity plans.
- *Administrative Requirements Reports.*
    - *Activities of the Member Advisory Group* (due semiannually). This report details the membership of the advisory group in addition to any orientation or ongoing training activities for advisory group members and minutes from each advisory group meeting.
    - *Service Denial Report* (due monthly). This report details all Enrollee Medicaid services denied through the Health Plan, including the number and type of requests denied, in addition to the reason for each denial.
- *HIPAA Report* (due quarterly). This report details any security incidents as defined by HIPAA, including the nature and scope of any incidents and the response to the incident.
- *Non-Discrimination Compliance Report* (due quarterly). This report details any complaints of discrimination filed against the Health Plan or the Health Plan's employees, providers, or provider subcontractors in which discrimination is alleged as it relates to the provision of or access to Medicaid services provided by the Health Plan.
- *Specialized Services Reports.*
    - *FQHC, Rural Health Center, and Indian Health Clinic Report* (due quarterly). This report includes encounter data records documenting the Health Plan's reimbursement to FQHCs, Rural Health Centers, and Indian Health Clinics.
    - *Developmental Disabilities (DD) Enrollee Details Report* (due quarterly). This report documents a variety of data elements for MMCP Enrollees accessing DD waiver or State Plan services. Detailed report specifications can be found in the SOW.

- *Aged and Disabled Waiver Enrollee Service Plan Reports* (due quarterly). These reports include a variety of data elements for MMCP Enrollees accessing Aged and Disabled waiver services. Detailed report specifications can be found in the SOW.
- *Financial Accountability—Fraudulent Billing Report* (due annually). This report identifies service providers who had fraudulent billing patterns that were investigated and actions taken by the Health Plan.

The IDHW contract monitor and other IDHW staff conduct monthly reporting meetings with the Health Plan to review report findings and request ad hoc reports when issues are identified or when additional data is desired to observe trends. In addition, the IDHW contractor monitor conducts quarterly site visits to the Health Plan's campus. During these quarterly visits, IDHW conducts a random sample file audit of the Health Plan's case management system in order ensure compliance with standards for care coordination, timeliness of noticing, system requirements, etc.

In addition, IDHW believes in fostering a strong, positive working relationship with the Health Plan and maintaining an ongoing transparent dialogue. IDHW and the Health Plan conduct semi-annual statewide meetings with the public to encourage stakeholder feedback and solicit input regarding the program, in addition to providing education about the program. This approach to partnership and transparency has been invaluable in improving the experience of our customers and maintaining the integrity of the program.

External Quality Review (EQR) (§438.204(d))

The IDHW has contracted with Qualis Health, a healthcare consulting and care management organization, as the state Medicaid program's Quality Improvement Organization. The existing contract was amended in June 2014 to include External Quality Review activities in relation to the Health Plan administering the MMCP for the July 2014 through June 2016 contract period. Qualis Health, performing as the External Quality Review Organization (EQRO) for the MMCP, will conduct the mandatory EQR-related activities outlined in 42 CFR §438.358, including validation of performance improvement projects underway during the previous twelve months, validation of performance measures reported during the previous twelve months, and a review to determine the Health Plan's compliance with standards for access to care, structure and operations and quality measurement and improvement. The EQRO will not perform the optional EQR-related activities at 42 CFR §438.358(c). In addition, the EQR will not use information from Medicare or private accreditation reviews and the state will not exercise the non-duplication option under 42 CFR §438.360(c) because IDHW intends for the EQR to address the Medicaid-only components administered by the plan with respect to the mandatory EQR activities. Because the MMCP administered by the Health Plan is a Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP), the Health Plan is already subject to review as a Medicare Advantage Plan. In addition, the Medicare review activities are not substantially comparable to the State-specified mandatory activities.

Section III: State Standards

Standards for Access, Structure and Operations, and Measurement and Improvement as described in the Scope of Work for the MMCP and established in operational protocols are described below.

Access Standards

Availability of Services and Assurances of Adequate Capacity and Services (42 CFR §438.206 and 42 CFR §438.207)

The IDHW ensures that the Health Plan's administration of the MMCP meets the availability of services and capacity requirements described at 42 CFR §438.206 and 42 CFR §438.207. The MMCP SOW contains provisions that address each requirement and the IDHW receives regular reporting on the Health Plan's provider network and the availability of services for MMCP Enrollees. The IDHW receives a quarterly provider enrollment file that specifies the number, type, and geographic distribution of the Health Plan's provider network. This data, in conjunction with enrollment information and risk tier distribution of the Enrollee population in a given geographic area, permits the IDHW to determine whether the Health Plan's provider network is robust enough to meet Enrollee needs.

On an annual basis, the Health Plan produces a geographic analysis of its provider network to determine the percentage of Enrollees in Idaho's urban counties that have access to a provider within thirty (30) miles of their residence and the percentage of those Enrollees residing in rural counties that have access to a provider within forty-five (45) miles of their residence. The report distinguishes between provider types: primary care, emergency services, behavioral health services, and home and community-based services. The Health Plan also provides the results of its annual provider network survey, which is used to determine provider compliance with the required timelines for care and service delivery. The SOW requires that the Health Plan's provider network be appropriate to meet the needs of the diverse MMCP population and must ensure the availability of services 24-hours a day when medically necessary.

In addition, all Health Plan policies, procedures and provider subcontracts are reviewed and approved by the IDHW contract monitor and policy staff prior to implementation. Health Plan documents are submitted to a secure SharePoint site electronically for review. Documents are either approved and the approvals submitted back to the Health Plan, or are rejected and the Health Plan receives a notification indicating the reason for the rejection. This process ensures that Health Plan policies and procedures, network contracts, and other MMCP documents are in compliance with applicable state and federal requirements and assurances.

Coordination and Continuity of Care (42 CFR §438.208)

The IDHW requires the Health Plan to adhere to the coordination and continuity of care requirements of 42 CFR § 438.208. The MMCP contains a Care Coordination element that functions as the hub of person-centered care delivery for MMCP Enrollees. To support a coordinated model of care, each Enrollee is assigned to a Care Coordinator upon enrollment in the MMCP. The Health Plan administering the MMCP receives an electronic eligibility file which includes rate code indicators for Enrollees – identifying those Enrollees who receive LTSS. This helps the Health Plan identify Enrollees with special health needs.

The Care Coordinator establishes contact with a new Enrollee within 30 days of enrollment to conduct the Probability of Repeated Admission (PRA) assessment, a brief health screening, for the purposes of assigning the Enrollee to a risk tier. The Care Coordinator then conducts a face-to-face comprehensive health risk assessment with the Enrollee – in most cases, this occurs within 30 days of enrollment. Together with the Enrollee, the Care Coordinator develops an Individual Care Plan (ICP) that addresses a continuum of Enrollee needs, in addition to identifying the Enrollee's preferences for care delivery and their personal goals and desired outcomes. Enrollees are permitted a 90-day transitional period upon enrollment into the MMCP which allows them to keep their current providers of services even if they are out-of-network. The Care Coordinator assists the Enrollee in identifying in-network providers of services and in transitioning those services as smoothly as possible.

The IDHW requires that the Health Plan make at least three attempts to contact an Enrollee, and those contact attempts must be documented. For Enrollees who cannot be reached or who refuse to participate in a health screening or a comprehensive health risk assessment, the Care Coordinator generates a basic care plan for the Enrollee and follows up in six months to offer Care Coordination services to the Enrollee again. The IDHW and Health Plan have determined that, for Enrollees accessing Medicaid LTSS through an HCBS waiver prior to their enrollment into the MMCP, collaboration between the IDHW Nurse Reviewer and the Health Plan Care Coordinator greatly improves the participation rate in Care Coordination.

The ICP documents information about members of the Enrollee's Interdisciplinary Care Team (ICT) which includes, at minimum, the Enrollee and their Care Coordinator, in addition to listing the Enrollee's primary care provider and contact information. If the Care Coordinator identifies that the Enrollee has unmet medical or social service needs, or requires specialist services, he or she assists the individual in accessing those services. This can include benefits administered by the MMCP in addition to community resources. The Care Coordinator also works to identify any potentially duplicative services to streamline care delivery for the Enrollee.

The Health Plan utilizes an electronic care plan that becomes part of the Enrollee's health record. This electronic format has greatly facilitated both the collection and dissemination of health information when necessary to members of the Enrollee's ICT and has proven to be an excellent validation tool for monitoring efforts. The IDHW is able to easily assess the Health Plan's compliance with a number of SOW and federal requirements regarding Care Coordination and continuity of care by conducting a random sample file audit during on-site visits, which includes a review of ICPs.

The Health Plan is compliant with HIPAA requirements and provides a copy of its HIPAA training materials and policies and procedures to the IDHW contract monitor annually for review.

At the time of writing, the Health Plan is currently exploring a pilot program of partnering with a Federally Qualified Health Center (FQHC) in Northern Idaho to furnish care coordination services to MMCP Enrollees who receive primary care services there. The IDHW and the Health Plan anticipate that the outcomes and lessons learned from this pilot will inform additional improvements to the MMCP care coordination and service delivery model.

Coverage and Authorization of Services (42 CFR §438.210)

The coverage offered under the MMCP includes those benefits under Medicare Parts A and B and the same benefits as are available under the Idaho Medicaid Enhanced Plan. The Health Plan is permitted to place appropriate limits on services based on medical necessity – a service is medically necessary if it is reasonably calculated to prevent, diagnose, or treat conditions in an Enrollee that endanger life, cause pain, or cause functionally significant deformity or malfunction; and there is no other equally effective course of treatment available or suitable for the Enrollee requesting the service which is more conservative or substantially less costly.

The IDHW ensures that the Health Plan processes initial and continuing authorizations for services in accordance with the SOW by reviewing and approving the Health Plan's policies and procedures for service authorization and by conducting a random sample file audit during on-site reviews. The IDHW also receives detailed information on all service denials issued by Health Plan on a monthly basis. This array of monitoring activities permits the IDHW to determine that the Health Plan makes authorization decisions within the required timeframes, and that any denials or authorization of services that are less than requested are made by appropriate personal and are not arbitrary decisions or made solely due to the diagnosis or type of illness of the Enrollee.

Structure and Operations Standards

Provider Selection (42 CFR §438.214)

The IDHW ensures that the Health Plan adheres to the provider selection requirements described at 42 CFR §438.214. Since the MMCP is a Medicare Advantage product, the Health Plan is also under the regulatory purview of Medicare credentialing requirements for those providers in its MMCP network furnishing Medicare-primary services. The Health Plan is required to implement a provider credentialing and re-credentialing system – and must submit its policies and procedures regarding this system to the IDHW annually or upon revision, whichever occurs first. The IDHW requires that the policies and procedures contain, at minimum, the following components:

- A training plan designed to educate staff in the credentialing and re-credentialing requirements;
- Provisions for monitoring and auditing compliance with credentialing standards;
- Provisions for prompt response and corrective action when non-compliance with credentialing standards is detected;
- A description of the types of Providers that are credentialed;
- Methods of verifying credentialing assertions, including any evidence of prior Provider sanctions;
- Prohibition against employment or contracting with Providers excluded from participation in federal health care programs; and
- Methods for certifying that each Provider license is current with the appropriate Idaho licensing bureau using the license and certification requirements for each individual Provider type.

The Health Plan may not discriminate against providers that serve high risk populations or specialize in conditions that require costly treatment. The IDHW receives a provider enrollment file on a quarterly basis that contains a listing by county of the providers in the Health Plan's MMCP network, including provider type and specialty. The IDHW also receives a monthly report identifying any providers investigated for potentially fraudulent billing patterns and any providers that were terminated. To date, the Health Plan has not terminated any MMCP provider of Medicaid-only services from its network. The IDHW requires that the Health Plan identify Enrollees that may be impacted by a provider termination to ensure that Enrollees are transitioned to other providers and continue to receive services.

Enrollee Information and Confidentiality (42 CFR §438.218 and 42 CFR §438.224)

The Bureau of Long Term Care, within the Division of Medicaid, provides information about the MMCP to potential enrollees and enrollees to assist them when needed in understanding the program. In addition, a Health Plan Outreach Specialist spends time at regional IDHW offices each month to answer questions and educate potentially eligible participants about the MMCP. The IDHW requires that the Health Plan make written material comprehensible and have a customer service line with language and format accessibility options available. The requirements for the Health Plan's customer service line, content and timeframe for notices, and minimum content required for the Enrollee Handbook meet the requirements of 42 CFR §438.218 and are described in detail in the SOW.

The Health Plan is compliant with HIPAA requirements and provides a copy of its confidentiality and HIPAA training materials and policies and procedures to the IDHW contract monitor annually for review.

Enrollment and Disenrollment (42 CFR §438.226)

Eligible Medicaid participants may voluntarily enroll or disenroll from the MMCP at any time, with or without cause. Both enrollment and disenrollment is prospective, with an effective date of the first of the calendar month following the request. The Health Plan is responsible for the following activities with respect to managing enrollments and disenrollments:

- Process all cancellations of voluntary enrollment.
- Process all voluntary enrollments.
- Process all voluntary disenrollments.
- Track information about all disenrollments.
- Ensure disenrollments requests received during any month are effective on the first calendar day of the following month.
- Cease the provision of Covered Services to an Enrollee upon the effective date of disenrollment.
- Notify the IDHW of any Enrollee who is no longer eligible to remain in the MMCP. This includes situations in which an Enrollee remains out of state or their residence in the state of Idaho cannot be confirmed for more than six (6) consecutive months.
- Transfer Enrollee record information promptly to any new provider upon written request by the Enrollee.

- Notify the IDHW if the Health Plan becomes aware that an Enrollee has comprehensive third-party insurance.

The Health Plan is prohibited from disenrollment of any Enrollee due to an adverse change in the Enrollee's health status or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. In specific circumstances, the Health Plan is allowed to involuntarily disenroll an Enrollee. This includes when the Enrollee's enrollment impairs the Plan's ability to furnish services to that Enrollee or other Enrollees, as long as this behavior is unrelated to the Enrollee's health status or utilization of services. The Health Plan has a written policy and process regarding involuntary disenrollments which has been reviewed and approved by the IDHW. In order to process an involuntary disenrollment, the Health Plan must submit a request to the IDHW contract monitor, with evidence, of the reason for the involuntary disenrollment request. If approved, the Enrollee is disenrolled from the MMCP effective the first of the following calendar month and reverted back to fee-for-service Medicaid and fee-for-service Medicare (unless they have chosen a Medicare Advantage plan).

Grievance Systems (42 CFR §438.228)

The Health Plan's grievance and appeal system conforms to the requirements of 42 CFR §438.228. The IDHW requires that an Enrollee access the Health Plan's appeal system prior to filing a state Fair Hearing request. The Health Plan provides information to Enrollees regarding how to file a grievance or appeal in the Enrollee handbook, and also provides assistance with lodging complaints or filing appeals through the Care Coordinator or through its Customer Service line.

The IDHW monitors the Health Plan's Grievance and Appeals system in a variety of ways. The IDHW and Health Plan utilize a secure SharePoint site built to house real-time grievance and appeal information. This has proven to be a useful tool, particularly in managing appeals that reach the state Fair Hearing level and ensuring that information regarding an appeal is readily available for review. The IDHW also reviews notices distributed by the Health Plan, customer service line recordings, case management notes, and other sources of data during on-site visits with the Health Plan. This permits the IDHW to corroborate information on any grievance or appeal that has been logged on the SharePoint site.

Subcontractual Relationships and Delegation (42 CFR §438.230)

The Health Plan maintains oversight and is responsible for any functions and responsibilities it delegates to MMCP subcontractor(s) in accordance with 42 CFR §438.230. All contracts that the Health Plan utilizes for subcontractors of MMCP functions must be submitted for review and approval by the IDHW contract monitor and policy staff to ensure compliance with the SOW and applicable state and federal regulations.

Since the launch of the program, the Health Plan has demonstrated a proactive approach in monitoring the performance of subcontractors and in resolving subcontractor issues that may arise. Network providers are monitored by the Health Plan in a number of ways:

- Monthly review of the provider file against the list of excluded and sanctioned providers
- Quarterly review of the Medicare Opt Out Report, which is a listing of providers who have elected not to participate in the Medicare program for reimbursement
- Monitoring of the Board of Medicine and other state boards for licensure compliance and actions against providers taken by their boards or the court system
- Formal credentialing occurs every three (3) years for all provider types
- Reviewing information from the Grievance and Appeals unit
- Reviewing feedback from the Quality Department
- Special Investigations Unit has routine audits to identify billing outliers, upcoding, unbundling, claims denied and resubmitted under another provider ID, as well as follows up on tips from the Hotline where potential provider fraud and abuse can be reported.
- Provider Network Management and Provider Relations follow up on complaints from or by providers regarding billing practices, quality of services, treatment of members, access to care, and other complaints or concerns as raised as well as identifying other issues when reviewing reports looking for outliers.

The IDHW requires that the Health Plan notify the contract monitor in the event of a subcontractor being placed on corrective action. To date the Health Plan has not issued a corrective action request to an MMCP subcontractor.

Measurement and Improvement Standards

Practice Guidelines (42 CFR §438.236)

The Health Plan is required to operate and maintain practice guidelines under its Utilization Management (UM) Program that complies with the requirements at 42 CFR §438.236. The IDHW requires that the Health Plan's UM program guidelines be based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field that ensure decisions for utilization management, Enrollee education, and coverage of services are applied in accordance with these guidelines. In addition, the practice guidelines must:

- Consider the needs of enrollees
- Be adopted in consultation with providers
- Be reviewed and updated as appropriate
- Be disseminated to all affected providers, and upon request to Enrollees and Potential Enrollees in a manner that is accessible and understandable.

Quality Assessment and Performance Improvement Programs (42 CFR §438.240)

The Health Plan has a robust quality management and quality improvement (QM/QI) program that applies to all of its product lines, including the MMCP (which is a Fully Integrated Dual Eligible Special Needs Plan). This program complies with the requirements described at 42 CFR §438.240 for Medicaid managed care plans, in addition to the requirements described in the Medicare Managed Care Manual and the National Committee on Quality Assurance (NCQA) Health Plan Accreditation requirements. The IDHW reviews the Health Plan's QM/QI program on an annual basis during the External Quality Review process.

The QM/QI program includes multiple committees within the Health Plan organization to provide oversight for various quality functions. The Health Plan's Board of Directors has assigned responsibility for QI/QM activities to the Quality Management Committee, which is responsible for the QI/QM program and oversight of various subcommittees. Subcommittees include, for example, the Medicare Advantage Member Advisory Panel, which serves as a platform for Enrollees to provide feedback and input regarding Health Plan policy and operations. The Service Quality Management Committee functions to promote superior customer service and increase member satisfaction. Subcommittees have the ability to recommend performance improvement projects to the Quality Management Committee for consideration.

At the time of writing, the Health Plan currently has three Performance Improvement Projects (PIP) underway related to the MMCP. The first is an examination of voluntary disenrollments from the plan. Over the first year of the expanded MMCP, the average disenrollment rate of the plan was approximately 7%. The Health Plan conducted exit interviews of Enrollees who elected to voluntarily disenroll from the plan to determine if there were trends in the reasons given for disenrolling from the product. The Health Plan has collected baseline data and has begun to implement changes to marketing strategies and customer communication in order to address some of the common reasons for disenrollment. The Health Plan is also currently testing three distinct interventions aimed at reducing hospital readmission rates. The third PIP, which is currently under development, will focus on promoting effective management of chronic disease.

A component of the Health Plan's administration of the MMCP is the promotion of effective utilization of medical care, including the evaluation of potential overutilization and underutilization of services. The Health Plan's UM program includes prior authorization review for medical/surgical services and certain medications, identified outpatient behavioral health services, admissions and concurrent review for inpatient services and behavioral health admissions and rehabilitation, and discharge planning. The UM process is based upon appropriateness of care and service delivery, cost effectiveness, and existence of coverage.

The Health Plan has been held to a high standard of performance for the MMCP and to date has worked collaboratively with the IDHW in meeting and exceeding the established performance expectations. The IDHW reserves the right to monitor the performance of any aspect of the SOW and seek remedial action, not just those elements identified in the Performance Indicators below. Each Performance Indicator has been assigned an expected performance threshold and a timeframe for reporting data on each element. Criteria established are subject to change based on updated legal or policy mandates.

Performance Indicator	Threshold	Review Period

Assessments Criteria: Reasonable efforts to complete Comprehensive Health Risk Assessments within required timeframes (within ninety (90) calendar days of enrollment and at least once every twelve (12) months thereafter).	95%	Quarterly
The Individualized Care Plan shall be developed for each Enrollee no later than 120 calendar days from the time of enrollment or within 30 calendar days of the completion of the Comprehensive Health Risk Assessment, whichever occurs first.	95%	Quarterly
Call Standards Criteria: 1) Percent of calls answered by a trained representative (non-recorded voice) within 30 seconds or less 2) The average wait time for assistance does not exceed one hundred twenty (120) seconds. 3) Call abandonment rate 4) Percent of provider services helpline and call center/help desk staff trained to provide customer service response to inquiries.	Call Standards 1) 80% 2) The quarterly average must be less than or equal to one hundred twenty (120) seconds. 3) <5% on average based on calls abandoned in the month divided by all incoming calls. 4) 100%	Quarterly
Claims Payment Criteria: 1) Percentage of clean claims the Health Plan paid within thirty (30) calendar days of receipt 2) Percentage of clean claims the Health Plan paid within ninety (90) calendar days of receipt	Claims Payment 1) 90% 2) 99%	Quarterly
Provide reports as outlined in the Reports/Records/Documentation Section and described in the Reporting Manual. Reports shall include data current through the respective reporting timeframe and shall be submitted within the required timeframe in the specified format.	100%	Quarterly

The Health Plan shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the Enrollee.	100%	Quarterly
Ensure consistent with 42 CFR § 438.6(h), 42 CFR § 422.208 and 422.210, that compensation to individuals or entities that conduct Utilization Management (UM) activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Covered Services to any Enrollee.	100%	Quarterly
Advocacy for Enrollees The Health Plan shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an Enrollee who is his or her patient, for the following: (i) The Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered. (ii) Any information the enrollee needs in order to decide among all relevant treatment options. (iii) The risks, benefits, and consequences of treatment or non-treatment. (iv) The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.	100%	Quarterly
Allow Enrollee self-direction of specified services through Personal Assistance Agencies (PAA) functioning as Fiscal Intermediary (FI) Agencies	100%	Ongoing
Adhere to managed care standards at 42 CFR § 438.214 and 42 CFR § 422.204, and shall be accredited or working toward accreditation by the NCQA and shall comply with procedural requirements for standards for credentialing and re-credentialing of licensed independent Providers and Provider groups with whom they contract, employ, who fall within their scope of authority and action, or with whom they have an independent relationship.	100%	Quarterly

Terminate, suspend, or deny enrollment to a Provider from its network as appropriate, and notify IDHW of such action immediately if a Provider is terminated or suspended from the Health Plan, Idaho Medicaid, Medicare, another state's Medicaid program, or is the subject of a State or Federal licensing Action or for any other independent Action.	100%	Quarterly
Maintain a network of Providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Enrollees in the service area	100%	Ongoing
Implement and maintain policies and procedures to provide information, choice, and to enroll eligible Enrollees who consent to participate in the IHCMFP upon transition from a Qualified Institution to a Qualified Residence within the community	100%	Ongoing

Health Information Systems (42 CFR §438.242)

The Health Plan is required to maintain information technology (IT) systems that meet the requirements detailed in the SOW in order to ensure adequate capacity and infrastructure to administer the MMCP. The Health Plan's IT systems underwent extensive testing and improvement during the readiness review phase in 2014 prior to the expanded MMCP going live. This included working closely with IDHW subject matter experts across a variety of areas to ensure that the Health Plan would be able to meet all of the IT requirements established in the SOW. The Health Plan continues to make improvements to its IT systems to support the MMCP.

In addition, the Health Plan is required to collect data on its IT system performance, including system outages or file transmission issues, eligibility and enrollment information, claims data, Enrollee and provider characteristics, and information regarding services furnished to Enrollees. The IDHW receives this data from the Health Plan on a routine basis for monitoring purposes. This information includes, but is not limited to,

- An electronic file of all finalized encounter data, including those of its subcontractors, to the IDHW and/or its designee on all Medicaid State Plan and Waiver services rendered.
- A Provider Enrollment report on an annual basis identifying all providers in its network that may furnish services to MMCP Enrollees.
- A Geographic Access Report and a Timeliness of Services Report, due annually, to quantify and demonstrate Enrollee access to the provider network.
- A daily 834 Benefit Enrollment and Maintenance transaction file (if new enrollments are available to process).
- A 270 eligibility request (if necessary).

Section IV: Improvement and Interventions

The MMCP is currently still in its nascent stages as an MCO; the expansion was launched July 2014 and the product is still in its early years of operations. The IDHW anticipates receiving the completed External Quality Review Technical Report from Qualis Health in the spring of 2016, which, in conjunction with the aggregated data from the first year of the expanded MMCP, will permit the IDHW to establish a performance baseline for the product. The IDHW and the Health Plan administering the MMCP will begin dialogue shortly to identify specific areas for improvement interventions and revisit the performance thresholds established in the original SOW. During this first year, IDHW and the MCO currently administering the MMCP have worked collaboratively to establish uniform data collection and reporting functions, resulting in amendments to the SOW effective May 1, 2015 and August 24, 2015. The purpose of the MMCP has been to test a new model of integrated service delivery for duals that is cost-neutral to the IDHW. Once the IDHW has complete encounter data, anticipated in fall 2016, the state will be able to identify additional opportunities for improvement with the MMCP model and to determine if better integrated care results in cost savings and improved quality of care for this population.

The MMCP has grown significantly in enrollment: approximately 600 enrollees were already enrolled in the previous PAHP MMCP, and enrollment in the expanded MCO MMCP has grown to 2,315 enrollees as of April 1, 2016. This is, however, a comparatively small population of the approximately 25,000 dual eligibles in Idaho. When the expanded MMCP launched in July 2014, the existing MCO offered coverage in 33 out of 44 Idaho counties. The MCO currently administering the MMCP has been approved by CMS to expand availability to all but Franklin and Lemhi counties in 2016. The initially small population has permitted extensive process improvement and collaboration with the Health Plan, as any identified issues can be remediated immediately with relatively little impact to Enrollees. IDHW continues to explore options to shift the administration of medical services from a volume-based system to a value-based system, and future changes to the MMCP will align with this goal.

Intermediate Sanctions (§438.204(e))

The IDHW Strategic Plan includes a goal of enhancing the delivery of health and human services, which applies across the spectrum of services and programs available under the purview of the Department. The goal of the MMCP is to enhance the quality of services furnished to duals while containing costs for this complex population. In order to ensure the integrity and quality of the MMCP, the IDHW has established a system of monitoring and oversight and a graded system of remediation when problems are identified.

The Contract Monitor issues a monthly monitor report that includes any identified SOW compliance issues from the previous reporting period. This report includes any applicable invoice reductions, as specified in the SOW. In the event of repeated or egregious noncompliance or quality issues, a corrective action plan is issued that requires a response from the Health Plan that describes in detail the steps it will take to remediate the problem and prevent it from recurring, in addition to a root cause analysis to identify what factors contributed to the identified issue. Invoice reductions may or may not be attached to a corrective action plan.

In the event that corrective action plans are insufficient to remediate an issue, the SOW has a detailed process for assessing liquidated damages. To date, the Health Plan's performance has not warranted this degree of action to correct a deficiency.

Optional temporary management may be imposed by IDHW if there is continued egregious behavior by the Health plan including criteria described in 42 CFR § 438.700, behavior contrary to any requirements of sections 1903(m) and 1932 of the Social Security Act, substantial risk to enrollee's health, or if temporary management is necessary to ensure the health of Enrollees while improvements are made to remedy violations under 42 CFR § 438.700 or until there is an orderly termination or reorganization of the Health Plan.

IDHW must impose temporary management if it finds the Health Plan has failed to meet the substantive requirements in section 1903(m) or section 1932 of the Social Security Act in accordance with 42 CFR § 438.706 (b). IDHW will not delay imposition of temporary management to provide a hearing before imposing this sanction, nor will it terminate temporary management until it determines that the Health Plan can ensure that the sanctioned behavior will not recur. IDHW will notify Enrollees that temporary management has been imposed and of their right to disenroll.

Health Information Technology (438.204(f))

The IDHW has partnered with its MMIS provider, Molina Medicaid Solutions, to develop innovative ways of supporting the quality of the MMCP within the Medicaid information technology system. The compatibility and streamlining of data transmission between the IDHW and Health Plan's information systems has been critical to the success of the program. The IDHW has developed an automated weekly status report of all system interactions with the Health Plan system, which has allowed the state to identify potential impacts to Enrollees as a result of system errors. A monthly monitoring report was also developed that provides an aggregate of system interactions for the month, including eligibility data, capitation payment information, systems availability, file transmission records, etc. The IDHW also performs a quarterly audit on the Health Plan's information system. The IDHW has also recently developed a real-time system for monitoring Health Plan appeals/grievances that permits review of notices of action and additional documentation instantaneously.

This tiered system for monitoring and oversight of information technology operations has allowed for continual review and assessment of the operations of the information system against quality goals. In addition, the approach of a blended information system allows for a shared responsibility between the state and the Health Plan to support quality and access for MMCP enrollees.

In addition, the Health Plan is continually improving its electronic provider portal to ensure providers furnishing services to MMCP Enrollees have the necessary information to best serve the participant. This includes making Enrollee Comprehensive Care Plans available to appropriate providers via the portal to support integrated care for the participant.

Section V: Delivery System Reforms

The Idaho State Legislature directed Idaho Medicaid to develop a Medicaid managed care system for dual eligibles with House Bill 260 in 2011. The purpose in developing a managed care approach for the dual-eligible population is two-fold. First, the differing coverage rules between Medicaid and Medicare systems results in fragmented care and poor health outcomes for a population that has high needs. The Medicaid and Medicare funding streams were not designed to operate in tandem for individuals accessing both programs simultaneously, and varying reimbursement rates and methodologies can cause confusion for beneficiaries trying to navigate each system and can create conflicting financial incentives for providers.

Second, the dual-eligible population is historically a high cost group compared to other populations. Full duals comprise only 13% of the aggregate Medicare and Medicaid beneficiary populations, but they account for 34% of the total spending for both programs.[i] The IDHW intended to participate in the duals demonstration through CMS, but was unable to do so with only one interested Health Plan. Instead of entering into a three-way contract with CMS and the Health Plan, the IDHW entered into an MCO agreement with the Health Plan to launch of a Fully Integrated Dual Eligible Special Needs Plan in July 2014.

The MMCP is available to full dual eligibles, defined as those individuals with full Medicaid benefits and Medicare Parts A and B. The program is not available to individuals that exclusively have Medicare Savings Program eligibility through Medicaid, such as the Qualified Medicare Beneficiaries (QMB) or Specified Low-Income Medicare Beneficiaries (SLMB). The program is also not available to individuals who have Medicare eligibility as a result of having End-Stage Renal Disease. The state identifies full-duals who are potential Enrollees through the Idaho Benefit Eligibility System (IBES). IBES processes and warehouses eligibility data for Idaho Medicaid beneficiaries. An automated interface with the Social Security Administration feeds real-time data on Medicare eligibility into IBES, both when individuals age into Medicare or receive Medicare coverage due to disability. The eligibility information is then passed to the MMIS. The MMIS sends a monthly eligibility file that contains full dual eligible members to the Health Plan via the 834 file transmission process for outreach purposes to potential Enrollees. In addition, IDHW uses this eligibility data to track enrollment trends and to conduct targeted education and outreach meetings statewide.

The MMCP SOW specifies a number of performance measures that are specific to this population and are targeted at improving the quality of care furnished by the Health Plan. The IDHW established performance thresholds of 95% for completion of a Health Risk Assessment within 90 days of enrollment and completion of an Individualized Care Plan within 120 days of enrollment for new Enrollees and annually thereafter. The IDHW believes that care coordination is the foundation of improving care quality and health outcomes for duals. To date, the Health Plan has performed well on both measures.

In addition, the Health Plan is expected to appropriately integrate long-term services and supports (LTSS) and facilitate coordination between LTSS and clinical providers. The Health Plan is expected to screen 100% of institutionalized participants (residing in a Skilled Nursing Facility, Intermediate Care Facility for the Intellectually Disabled, or Institution for Mental Disease) for participation in the Idaho

Home Choice Money Follows the Person program. This program assists in transitioning institutionalized individuals into community settings, which results in decreased cost of care and improved quality of life for participants. The MMCP includes benefits that are part of Idaho's 1915(c) Aged and Disabled Home and Community-Based Services waiver, State Plan Personal Care Services, and Targeted Service Coordination for individuals with developmental disabilities, giving the Health Plan the flexibility and full scope of services to meet the continuum of needs for duals.

Section VI: Conclusions and Opportunities

The state experiences ongoing challenges and opportunities for improvement in the administration of the MMCP. At the time of writing, it is still very early in the life of the program. The IDHW and the Health Plan have worked collaboratively over the first year of the program to identify problems and improve reporting, communication, and systemic issues. While the current voluntary enrollment mechanism has resulted in a relatively small percentage of duals electing to enroll in the MMCP, the state and Health Plan continue to look for ways to increase enrollment in the MMCP. However, this relatively small group of Enrollees has allowed the IDHW and Health Plan the ability to remediate issues rapidly and tackle new or unforeseen problems effectively. In addition, the systems issues that inevitably occur with new or complex programs have been identified and corrected with minimal impact to Enrollees. The system error rate during the previously existing MMCP had a high average, but this average has been reduced to lower than 5% since the expansion of the MMCP in July 2014, due to increased monitoring and utilizing new mechanisms to hold the Health Plan accountable for performance. The IDHW and Health Plan have been able to remain vigilant of systems issues and to resolve any problems quickly due to the small population size. This has put the program in an excellent position to ensure that the system is operating smoothly in the event that enrollment grows rapidly in the future.

Among the most significant lessons learned through this process is that having a strong, positive working dynamic between the Health Plan ultimately facilitates quality improvement and improving health outcomes for MMCP Enrollees. Maintaining an open and transparent line of communication between the IDHW and the Health Plan and an atmosphere of collaboration has fostered a philosophy of continuous quality improvement. The IDHW has established stringent oversight of quality for the administration of the MMCP, which has allowed for the evolution of mutual respect on behalf of both the IDHW and the Health Plan with roles clearly defined and executed.

Working together with the Health Plan to conduct semiannual statewide stakeholder outreach meetings has proven to be an effective tool to simultaneously gather feedback from the public about the program and to provide education and information to potential Enrollees. These statewide engagement forums have been the source of a number of improvements made over the last year, including improving communication with providers and strengthening the coalition between the Health Plan and community networks of healthcare agencies to provide better care for Enrollees.

The IDHW and the Health Plan continue to work together to improve the care management model for Enrollees. We believe that it is integral to the success of the MMCP and to improving health outcomes

for the population. In September 2015, the IDHW Contract Monitor conducted a one-day site visit with the Care Management contractor for the Health Plan to observe the model in real-time. The state has used the information gleaned from this visit, in addition to research and dialogue with other states, to work with the Health Plan in improving the care management model. The visit also provided an opportunity to observe that the comprehensive health risk assessment did not meet the vision of the tool as intended – it was lengthy and cumbersome for participants. The IDHW and Health Plan have been working towards a more streamlined comprehensive health risk assessment that improves customer experience with the process while obtaining only the relevant information needed for the participant's care plan. We look forward to learning from experience and to gleaning from other states' successes and challenges in this service delivery model to further improve this product.

[i] See Congressional Budget Office, *Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies* (Congressional Budget Office, June 2013).